

## Department of Health and Social Services Division of Public Assistance Family Nutrition Programs Alaska WIC Program (907) 465-3100



## **WIC Stocking Request Form**

Store Name:	WIC Vendor Number:		
Manager Name:	Phone #:	Fax #:	
Address:	_ City:	State/Zip:	
Local WIC Agency:			
The Local WIC Agency requests the Vendor named indicated quantities:	above to stock	the following items, and to maintain	th
WIC Item (check ✓)	Quantity	to Stock (per month)	
infant formula: Similac Advance Early Shield			
infant formula: Similac Sensitive Isomil Soy			
infant formula: Similac Sensitive			
infant formula: (other)			
infant cereal, fruits and vegetables, and meats			
lactose free or reduced milk			
soy beverage			
tofu			
The Vendor is requested to order the designated WIC ite responsibility to communicate directly with the Local WI item(s) are not available due to unforeseen reasons, the that clients can be placed on the mail-out system.  The Vendor must maintain the quantity indicated for at the community. After 6 months, the Vendor may submit review the needs for Vendor to continue stocking the design vendor submit invoices or purchase orders from their sup within the specified time period, in the quantity required	C agency concern Vendor will notify least six (6) montl t an Exemption Re signated WIC iten pplier(s) to docum	ing the availability of exempted items. If the Local WIC Agency within 48 hours so as to meet the needs of WIC participants quest form for the Local WIC Agency to as. The State agency may require that the	the O
Vendors should direct any questions to their Local Agen	су.		
Local Agency Staff Name and Signature	Date	Phone	

WIC COORDINATOR: Send a signed request to the Vendor and send a copy to the State agency for Vendor File. Retain a copy for your records.